



Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Head Start/Early Head Start  
**ATTENTION:** Health Services Coordinator  
 126 Woodlake DR SE  
 Rochester, MN 55904  
 Phone: 507.424.1532 or 1.800.462.1660  
 Fax number: 507.287.2411

***A Yearly Dental Examination is a Federally Mandated Head Start Program Requirement***

Services	Date Services Completed
Examination/BSS	
X-Ray (if necessary)	
Preventative Services (if necessary)	
Prophylaxis (if necessary)	
Fluoride Treatment (if necessary)	
Sealants (if necessary)	
Restorative Services (if necessary)	

*IF HEAD START will be billed for treatment, an estimate **MUST** be approved in advance!*

- Please Check:
- has completed all necessary dental treatment and should return in \_\_\_\_ months for a routine visit.
  - treatment discontinued.
  - fluoride prescribed and dosage level \_\_\_\_\_.
  - this child needs nutrition counseling from a dental standpoint.
  - my office will provide this treatment
  - my office has referred the child to \_\_\_\_\_.

**Please List Future Routine or Treatment Scheduled Appointment Date(s):** \_\_\_\_\_

Comments: \_\_\_\_\_

I hereby certify that the services listed above have been performed:

Signature of Dentist/Hygienist

Print Name

Address

Phone